Similarities and Differences of Health-promoting Leadership and Transformational Leadership

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Abstract

The concept of health-promoting leadership focuses on the interaction between the organization and the individual by identifying components able to positively influence employees' working conditions. In the present study, the effects of health-promoting leadership and transformational leadership on the employees' recovery–stress balance are investigated. In an online study, 212 Slovenian workers were asked about their perceptions of their direct supervisors and their work-related stress and recovery. The results showed that both leadership styles have a significant effect on employees' recovery at the workplace, which mediated the relationship between leadership and work-related stress.

Keywords: conditions; health-promoting leadership; transformational leadership; stress; recovery; working environment

1 Introduction

The success of maintaining a psychologically healthy workplace lies in a systemic approach combining individual and organizational factors (Cotton & Hart, 2003; Shain & Kramer, 2004). By identifying critical aspects on the individual and organizational levels, intervention methods for a healthy, sustainable workplace can be developed more efficiently. Mismatches between the individual and organization are the focus of the six areas of worklife (Leiter & Maslach, 1999; Maslach & Leiter, 2008). By reducing these mismatches, it is possible to reduce stress and

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possible consequences such as burnout risk. Leaders can influence critical working conditions; therefore, they are often seen as important key factors in creating successful healthy workplaces (Aitken, 2007). With the help of health-promoting leadership, leaders are able to identify and reduce mismatches between individual and workplace (Jiménez, Winkler, & Dunkl, 2013).

The present paper focuses on two leadership styles (health-promoting leadership and transformational leadership) and their relation to employees' perception of stress and recovery. Stress can be seen as a process caused by an overly heavy load or demands. The experience of stress can be reduced by recovery processes that aim to re-establish personal resources and their full functional capacity. If stress at the workplace is not minimized with the right recovery strategies, major long-term consequences of stress can occur, such as burnout (Kallus, in press). Therefore, an individual is healthy if stress and recovery are kept in balance. Leadership can support health at the workplace by minimizing stress, enhancing recovery, and consequently reducing the risk of burnout.

Both, health-promoting leadership and transformational leadership are considered as leadership styles that aim to enhance positive work-related behaviors as well as reduce stress and the risk of getting burnout. Limited research exists that compares these two leadership styles in combination with organizational outcomes. In addition, the relationship between leadership and stress has been well investigated (e.g., Densten, 2005; Gill, Flaschner, & Shachar, 2006; Kanste, Kyngäs, & Nikkilä, 2007), whereas the impact on other work-related outcomes—such as recovery—has been less studied.

The purpose of this study is to investigate the impact of these two leadership styles on employees' recovery–stress balance. Another aim of this study is to compare the concepts of health-promoting leadership and transformational leadership and to identify similarities and differences.

2 Theoretical Background

2.1 Health-promoting leadership

Health-promoting leadership and its focus on enhancing healthy working conditions are based on the six areas of worklife (Leiter & Maslach, 1999; Maslach & Leiter, 2008), where mismatches between employees and their workplaces can occur. Leaders who recognize and reduce these mismatches are able to create a workplace that enhances health (Jiménez et al., 2013).

Workload. An increased workload is known to have a consistent relationship with emotional exhaustion, which is seen as an indicator for burnout (Maslach & Leiter, 2008). One major aspect of health-promoting leadership is to keep the workload at an adequate level, either by giving enough resources to manage increased workload or raising opportunities for recovery.

Control. Control has a positive effect on employee health (Schreurs, van Emmerik, Notelaers, & De Witte, 2010; Thompson & Prottas, 2006). Many possibilities exist for giving control in the workplace (autonomy, being involved in decision making, etc.) (Bakker, Demerouti, & Euwema, 2005; Nahrgang, Morgeson, & Hofmann, 2011).

Reward. Reward is an important part of the positive relationship between leaders and employees and can be either extrinsic (e.g., financial) or intrinsic (e.g., praise). Insufficient reward can increase the risk of burnout (Kivimäki, Vahtera, Elovaino, Vitanen, & Siegrist, 2007; Maslach & Leiter, 2008). Leaders can give many forms of non-financial rewards, such as existential recognition (personal or group recognition) or recognition of work practice, job dedication, and results (Brun & Dugas, 2008).

Community. A working climate, where employees have a positive connection with their coworkers and support each other, is another major aspect of health-promoting leadership. A positive working climate has an effect on performance, customer satisfaction, or perception of organizational justice (Schneider, Erhart, & Macey, 2013). Therefore, creating a working climate, where all employees are treated with appreciation and respect, is an essential task for leaders.

Fairness. Organizational fairness is one of the most important working aspects; unfairness has a negative effect on their well-being (Robbins, Ford, & Tetrick, 2012). In the sense of health-promoting leadership, employees should be treated fairly regarding decisions and procedures, and all means should be shared correctly.

Value-fit. Every person has different ideals and different moral concepts, which can be described as individual values. If the employees experience a gap between individual and organizational values, the risk of experiencing burnout increases (Leiter, Frank, & Matheson, 2009). Leaders can reduce differences between individual and organizational values by actively communicating the organizational norms and ideals or by ensuring that employees' tasks correspond with the organization's values.

Health awareness. An aspect not found in the areas of worklife but connected with employee health is the aspect

Figure 1. Dimensions of health-promoting leadership

of health awareness. Leaders with high health awareness tend to have more healthy employees (Franke, Felfe, & Pundt, 2014). Specific leadership behaviors involve communication about health-related topics, setting agendas for workplace health promotion, and motivating employees to participate in health-promotion activities (Gurt, Schwennen, & Elke, 2011).

By adding the health awareness dimension to the six areas of worklife, seven key aspects of health-promoting leadership can be defined (see Figure 1). Considering these dimensions, leaders are able to positively influence the working environment (i.e., the conditions) for their employees.

2.2 Transformational leadership

Transformational leaders are often described as charismatic leaders that are able to inspire their followers, meet their emotional needs, and/or intellectually stimulate them (Bass, 1991). The concept of transformational leadership consists of four subcategories (Bass & Steidlmeier, 1999). Inspirational motivation refers to articulating and representing a vision, which means that leaders are giving employees a positive and optimistic vision of future developments. Individualized consideration describes the degree to which leaders attend to their employees' needs. It includes listening to the employees' concerns and acting as mentors or coaches. Idealized influence (attributed or behavior) mainly focuses on charisma. A leader is attributed as charismatic and can act as a role model if he/she displays certain positive attributes, such as focusing on higher-order ideals and values. Finally, intellectual stimulation means that leaders encourage innovative and creative ideas from their employees and have a positive opinion about changing old practices if they prove to be ineffective.

Transformational leadership has been shown to be related with lower stress at work (Gill et al., 2006) and a lower burnout risk (Densten, 2005; Kanste et al., 2007). Furthermore, strong evidence has demonstrated that transformational leaders are able to influence work aspects, such as meaningful work environment, role clarity, and opportunities for development (Nielsen, Randall, Yarker, & Brenner, 2008). It is also positively related to variety (using different skills and talents), identity (completion of a "whole" piece of work), significance (having a meaningful job), autonomy (substantial freedom in decisions and actions), and feedback (Piccolo & Colquitt, 2006).

2.3 Health in organizations: The concept of recovery/stress imbalance

Two requirements must be fulfilled when defining organizational health: (1) Health is understood on a physical, mental, and emotional/social level, which means a holistic perspective of health (Antonovsky, 1997; Kelloway & Day, 2005) and (2) health in organizations must focus on an organizational and not only individual level by focusing on the organization as a system (Cotton & Hart, 2003; Grawitch, Gottschalk, & Munz, 2006).

Antonovsky's (1997) model of salutogenesis considers both requirements. It defines the "feeling of coherence," which consists of three components: (1) sense of comprehensibility, (2) sense of manageability, and (3) sense of meaningfulness. People with high scores on these three components have a high feeling of coherence. This leads to a flexible way to react to different demands and develop specific coping strategies for these demands.

Another concept that describes adaptation processes in the workplace is the recovery–stress balance model (Jiménez & Kallus, 2005). It is assumed that stress in particular can be considered harmful if the relationship between stress and recovery is imbalanced. The balance gets worse if prolonged stressful situations occur together with repeated shortened recovery or lacking resources. This imbalance affects negative emotional and motivational changes, which in turn leads to higher stress. Regulating the balance by developing successful recovery strategies or activating individual resources can cancel this self-reinforcing process and restore health (Jiménez & Kallus, 2005). Research shows that social support (support from coworkers or supervisors), work-related resources (e.g., autonomy, job control, and opportunity to use skills), undisturbed breaks, and leisure time are particularly able to buffer possible negative outcomes (Bakker et al., 2005; Halbesleben, 2006; Jiménez & Kallus, 2005).

2.4 Conceptual model and hypotheses

In the present study, two leadership strategies—health-promoting leadership and transformational leadership—are investigated. Referring to past research, we hypothesize that health-promoting leadership and transformational leadership show direct paths to both recovery and stress, influencing both aspects simultaneously. Furthermore, in line with the recovery–stress balance model (Jiménez & Kallus, 2005), recovery has an effect on stress, thereby moderating the relationship between both leadership constructs and stress.

Hypothesis 1: Health-promoting leadership and transformational leadership are positively related to the employees' recovery at the workplace.

Hypothesis 2: Health-promoting leadership and transformational leadership are negatively related to employees' stress.

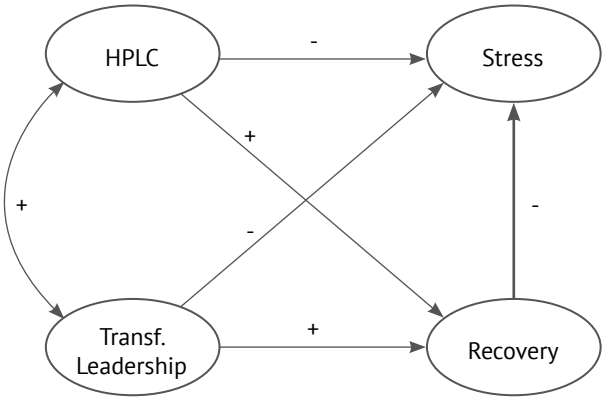
Hypothesis 3: Recovery moderates the relationship between health-promoting leadership/transformational leadership and stress.

We further hypothesize that the concepts of health-promoting leadership and transformational leadership are related, but can be seen as clearly different constructs and can be distinguished:

Hypothesis 4: The seven dimensions of health-promoting leadership and the scales of transformational leadership show low positive correlations, indicating discriminant validity.

All hypothesized relations between all variables are depicted in figure 2.

Figure 2. Hypothesized model of HPLC, transformational leadership, and recovery–stress balance



3 Methodology

3.1 Sample and procedure

Slovene workers were invited to participate in an online study[1] in cooperation with a well-known German market research company. Ultimately, 212 responses were collected. A comparison with the Slovenian working population is depicted in Table 1.

Table 1. Comparison of Sample Characteristics (Study Sample and Slovenian Working Population)

	Study sample	Slovenian population*
Gender		
male	47.2%	54.8%
female	52.8%	45.2%
Age		
up to 30 years	20.8%	13.3%
31–40 years	41.0%	30.7%
41–50 years	25.0%	31.2%
51 years and older	13.2%	24.9%

Note: *Persons in employment by register
Source: Republic of Slovenia Statistical Office (2015)

The participants worked in different industrial sectors; the majority worked in manufacturing (20.8%), public sector (16.5%), education (8.0%), commerce (8.0%), and telecommunications (7.5%). The sample consisted of 52.8% women and 47.2% men. The majority of the participants (41.0%) were between 31 and 40 years old; 25.0% were between 41 and 50 years old, and 20.8% were 30 years or younger. In addition, 59.0% had a graduate degree. Finally, 42.5% had worked longer than 10 years and 26.4% worked 5 to 10 years in their current company.

3.2 Measurement instruments

To measure the extent of health-promoting leadership, the health-promoting leadership conditions questionnaire (HPLC; Jiménez et al., 2013), including seven dimensions (i.e., health awareness, low workload, control, reward,

[1] Data were collected within the culture4leadership project funded by the Styria federal state within the "grenz-frei" framework.

community, fairness, and value fit) was used. The HPLC can be used as a self-assessment or objective assessment tool. In this study, only the objective assessment tool was used, where employees assess their direct supervisors. Participants answered 21 items on a 7-point Likert scale ranging from 0 = "never" to 6 = "always."[2] All items are shown in Table 2.

The Multifactor Leadership Questionnaire (MLQ) measures a broad range of leadership types, from passive leaders to transformational leaders. In the present study, an adapted version of Felfe and Goihl's (2014) questionnaire was used. Three scales that measure transformational leadership were included in the analysis: idealized attributes, inspirational motivation, and individualized consideration. The answer scale ranged from 1 = "not at all" to 5 = "frequently, if not always."

The Recovery–Stress Questionnaire for Work (RESTQ-Work/55; Jiménez & Kallus, 2005) addresses different aspects of stress and recovery during the past seven days/nights. The 55 items can be categorized in seven sub-dimensions: social emotional stress, performance-related stress, general recovery, loss of meaning/burnout, leisure/breaks, psychosocial recovery, and work-related recovery. These seven sub-dimensions can be categorized into the stress and recovery dimensions. The scale that was used was a 7-point Likert scale ranging from 0 = "never" to 6 = "always."[3]

3.3 Translation procedure

All questionnaires were translated into the Slovene language using three translators. First, two independent translators created their translations of the questionnaires used in this study. After receiving two different translations, discrepancies in the two translated versions were discussed by the two translators and an additional third translator. To guarantee a high-quality translation, one of the three translators was a psychologist. The translated questionnaires were used in this study for the first time.

3.4 Statistical analyses

To test our hypotheses, we used several different methods, including confirmatory factor analysis (CFA) and other statistical analyses based on the assumption of interval data. The usage of 5- or 7-point Likert scales as interval scales is "the most common form of measurement used in psychological research" according to Langdridge (2009, p. 46) and is considered an acceptable procedure. The statistical requirements for all analyses were tested and fulfilled.

4 Results

4.1 Item analysis, reliability, and validity of the measures

All items of the HPLC as well as means and standard deviations are shown in Table 2. To obtain the reliability estimates for all study variables, the internal consistency assessed by Cronbach's alpha was used (see Table 3; internal consistencies of all study variables are printed in the diagonal). The internal consistencies range between .81 and .93.

The correlation table (Table 3) shows that all dimensions measuring health-promoting leadership are positively related (.75 to .88) and show moderate positive correlations with the MLQ scales (.27 to .42). Correlations between the HPLC and the stress-related dimensions of the RESTQ-Work are low, but significant (-.11 to -.23). Higher correlation coefficients (.23 to .48) can be found when correlating the HPLC with the recovery-related dimensions of the RESTQ-Work.

For the MLQ, intercorrelations between the three scales are high, ranging from .80 to .85. The relationships between the MLQ and the stress-related dimensions of the RESTQ-Work are low, although significant (-.14 to -.27); correlations with the recovery-related dimensions of the RESTQ-Work are higher (.23 to .56). The correlation matrix as well as the means and standard deviations for each dimension can be found in Table 3.

The convergent validity, discriminant validity, and reliability were then assessed for all constructs with an exploratory factor analysis (Table 4). All factor loadings are higher than .6, and the average variance extracted (AVE) exceeded the suggested limit of .5, confirming convergent validity (Fornell & Larcker, 1981). Discriminant validity was tested with Fornell and Larcker' (1981) recommended test, where all square roots of the AVE for a given latent construct are greater than the standardized correlation of the pairs of latent constructs (Table 5). Composite reliability was used to assess the internal consistency of the constructs. All composite reliability coefficients were higher than .8, indicating good reliability.

[2] In the HPLC, the Likert scale starts with zero to achieve a better match between verbal and numerical codes—more specifically, a better match between zero and the "never" event.

[3] In RESTQ-Work, the Likert scale starts with zero to achieve a better match between the verbal and numerical codes—more specifically, a better match between zero and the "never" event.

Table 2. Dimension, Means (M), Standard Deviations (SD), and Items of the HPLC

Dimension	N°	M	SD	Items My leader takes care that…
Health awareness	HA_1	3.28	1.77	… the health of all employees is promoted.
	HA_2	3.16	1.87	… all employees are motivated to take care of their health.
	HA_3	3.33	1.79	… the health of the employees is highly valued.
Low workload	WL_1	3.48	1.69	… there is enough time left for the work to be done.
	WL_2	3.15	1.76	… work under high pressure is not carried out over a longer period of time.
	WL_3	3.22	1.66	… work does not significantly affect private life.
Control	CT_1	3.00	1.64	… the resources and scope for personal development at work can be influenced.
	CT_2	3.95	1.60	… at work autonomous and independent action can be taken.
	CT_3	3.47	1.61	… all have the necessary scope to do their work.
Reward	RE_1	3.64	1.89	… work is appreciated.
	RE_2	3.79	1.67	… efforts do not go unnoticed.
	RE_3	3.51	1.79	… all contributions are being acknowledged.
Community	CM_1	3.79	1.67	… work colleagues support each other.
	CM_2	3.18	1.62	… there is a good cooperation between all work colleagues.
	CM_3	3.73	1.70	… work colleagues talk openly to each other.
Fairness	FA_1	3.01	1.89	… all resources are fairly distributed.
	FA_2	3.53	1.92	… all employees are treated in a fair manner.
	FA_3	3.50	1.99	…one's career depends on competencies and not on the connections someone has.
Value fit	VA_1	3.21	1.65	… the employees share the company's values.
	VA_2	3.81	1.62	… the employees' daily activities correspond with the company's objectives.
	VA_3	3.31	1.69	… personal career interests are in line with the objectives of the company.

Note: Answer scale: 0 = "never" to 6 = "always"

Table 3. Means, Standard Deviations, Internal Consistencies, and Correlations among the Dimensions of the HPLC, MLQ, and RESTQ-Work; Internal Consistencies (Cronbach's Alpha) in the Diagonal

No.	Dimension	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	HPLC: health awareness	3.26	1.68	.92																
2	HPLC: low workload	3.28	1.51	.78*	.87															
3	HPLC: control	3.48	1.37	.75*	.82*	.81														
4	HPLC: reward	3.65	1.57	.79*	.75*	.82*	.86													
5	HPLC: community	3.57	1.46	.77*	.84*	.88*	.83*	.85												
6	HPLC: fairness	3.35	1.74	.78*	.82*	.79*	.87*	.88*	.88											
7	HPLC: value fit	3.44	1.44	.87*	.78*	.83*	.81*	.84*	.81*	.85										
8	MLQ: idealized attributes	2.96	1.15	.27*	.29*	.35*	.33*	.36*	.38*	.34*	.93									
9	MLQ: inspirational motivation	3.36	0.97	.33*	.34*	.42*	.38*	.39*	.40*	.40*	.81*	.82								
10	MLQ: individual consideration	2.97	1.06	.36*	.37*	.41*	.38*	.41*	.42*	.40*	.85*	.80*	.84							
11	RESTQ-W: social emotional stress	2.05	1.26	-.22*	-.17⁺	-.17⁺	-.17⁺	-.18⁺	-.15⁺	.15⁺	-.14⁺	-.14⁺	-.16⁺	.91						
12	RESTQ-W: performance-related stress	2.17	1.12	-.19*	-.23*	-.19*	-.15⁺	-.17⁺	-.18⁺	-.14⁺	-.15⁺	-.15⁺	-.19*	.81*	.87					
13	RESTQ-W: general recovery	3.40	0.99	.39*	.37*	.37*	.37*	.41*	.39*	.38*	.34*	.36*	.37*	-.48*	-.47*	.86				
14	RESTQ-W: loss of meaning/burnout	2.12	1.14	-.16⁺	-.19*	-.17⁺	-.11⁺	-.18⁺	-.13⁺	-.11⁺	-.22*	-.24*	-.27*	.75*	.76*	-.41*	.92			
15	RESTQ-W: leisure/breaks	2.90	1.07	.26*	.36*	.27*	.26*	.31*	.30*	.23*	.18⁺	.23*	.27*	-.47*	-.52*	.66*	-.44*	.83		
16	RESTQ-W: psychosocial recovery	3.17	1.32	.29*	.27*	.35*	.34*	.42*	.34*	.32*	.23*	.30*	.30*	-.26*	-.25*	.66*	-.17⁺	.57*	.86	
17	RESTQ-W: work-related recovery	3.19	1.23	.34*	.37*	.48*	.44*	.48*	.43*	.44*	.48*	.56*	.53*	-.28*	-.24*	.66*	-.22*	-.52*	.61*	.90

Note: ⁺ significant correlation ($p < 0.05$); * significant correlation ($p < 0.01$)

Table 4. Second-order Constructs, Their Loadings, Composite Reliabilities (CR), and Average Variance Extracted (AVE)

Second-order item	Item	Loadings (lambdas)	CR	AVE
HPLC	HPLC: health awareness	.82	.97	.80
	HPLC: low workload	.89		
	HPLC: control	.93		
	HPLC: reward	.88		
	HPLC: community	.95		
	HPLC: fairness	.89		
	HPLC: value fit	.90		
Transf. Leadership	MLQ: idealized attributes	.92	.93	.83
	MLQ: inspirational motivation	.87		
	MLQ: individual consideration	.93		
Stress	RESTQ-W: social emotional stress	.91	.91	.78
	RESTQ-W: performance-related stress	.90		
	RESTQ-W: loss of meaning/burnout	.84		
Recovery	RESTQ-W: recovery	.88	.87	.62
	RESTQ-W: leisure/breaks	.76		
	RESTQ-W: psychosocial recovery	.74		
	RESTQ-W: work-related recovery	.76		

Table 5. Square Root of the AVE and Correlations among the Second-order Constructs

	Transf. Leadership	HPLC	Stress	Recovery
Transf. Leadership	**.91**			
HPLC	.45	**.89**		
Stress	-.22	-.20	**.88**	
Recovery	.48	.49	-.53	**.79**

Note: Square root of the AVE in the diagonal and bolded.

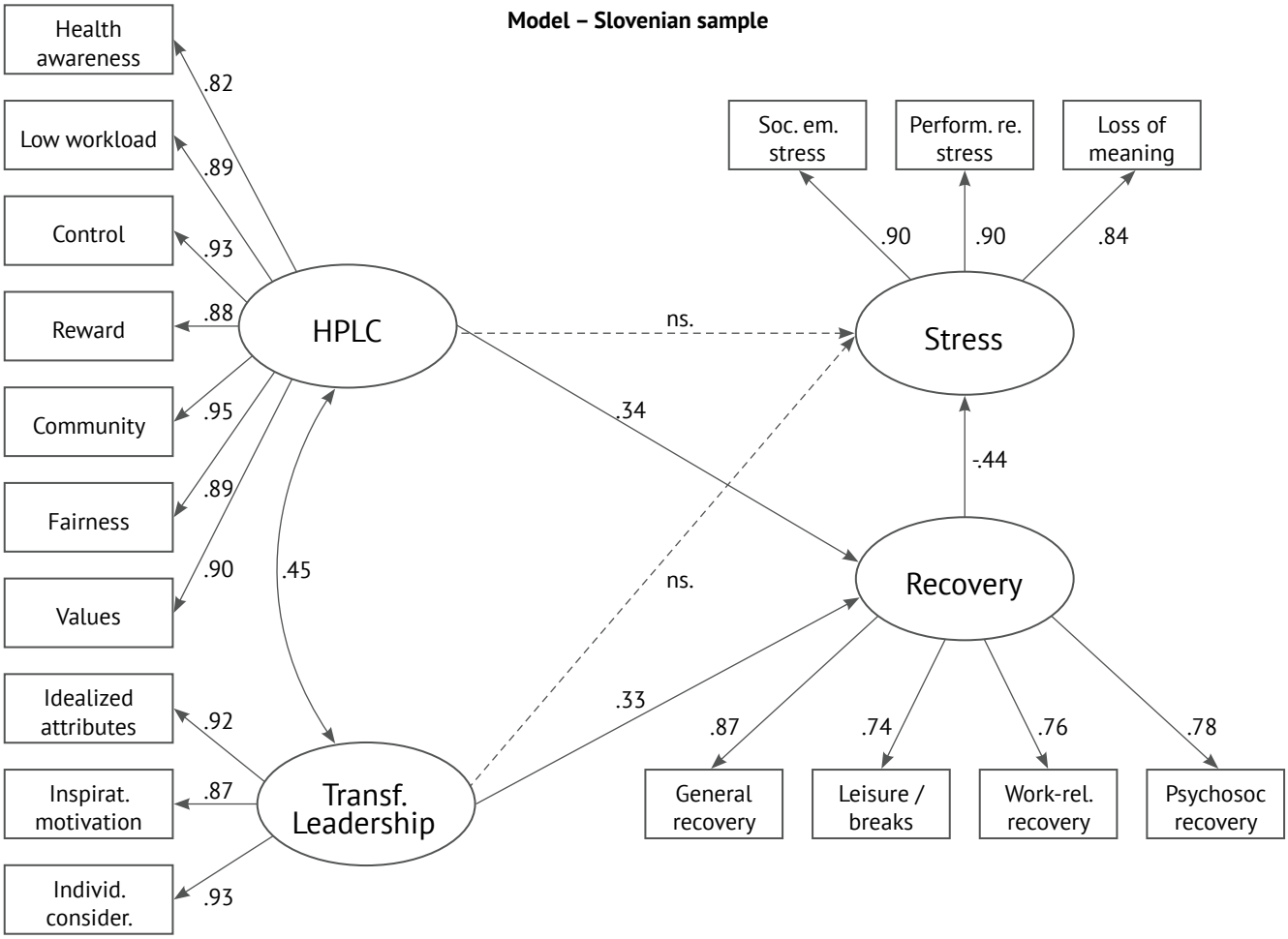
4.2 Structural equation modeling (SEM)

In the structural equation modeling (conducted with maximum likelihood method of estimation), health-promoting leadership (HPLC), transformational leadership (MLQ), and recovery and stress were included as latent factors, operationalized by their assigned dimensions as manifest variables. For this analysis, only data without any missing values were analyzed, resulting in a data set of 187 cases.

The model reached an acceptable fit, indicating that the hypothesized model fits with the empirical found data. The chi-square statistic was statistically significant ($\chi^2(104) = 195.270$, $p < .001$), and the fit indices show good values (AGFI = .84, GFI = .89, CFI = .97, RMSEA = .07). The AGFI and GFI do not exceed the recommended value of .85 and .90, respectively, but are relatively close to these recommendations, which can be regarded as acceptable (e.g., Hu & Bentler, 1999; Schermelleh-Engel & Moosbrugger, 2003).

Most of the predicted paths are in the expected direction (Figure 3). Health-promoting leadership (HPLC) and transformational leadership are correlating positively (.45). HPLC is negatively related to the experience of recovery ($\beta = .34$, $p < .001$) and recovery in turn has a negative effect on stress ($\beta = -.44$, $p > .001$), which makes recovery the mediator in the HPLC-stress relationship. Mediating impacts presented in Table 6 were tested as proposed by Baron and Kenny (1986). The significance of indirect effects was assessed with bootstrapping (Preacher & Hayes, 2008). As observed from Figure 3, HPLC has a significant indirect negative impact on stress through recovery ($\beta = -.15$, $p < .01$). Transformational leadership is not directly related to stress, showing only a significant path to recovery ($\beta = .33$, $p < .001$).

Figure 3. Regression coefficients for the HPLC model



Note: N = 187; non-significant regression coefficients removed, other regression coefficients significant with $p < 0.001$; $\chi^2 = 195.270$, df = 104, $p < 0.001$, AGFI = .84, GFI = .89 CFI = .97, RMSEA = .07

Table 6. Direct, Indirect, and Total Impact for the HLPC Model

	Direct impact	Sig.	Indirect impact	Sig.	Total impact	Sig.
HPLC --> Recovery	.34	p<.01	n/A	n/A	.34	p<.01
HPLC --> Stress	.00	ns.	**-.15**	**p<.01**	-.15	ns.
Transf. Leadership --> Stress	-.05	ns.	-.15	p<.01	-.19	p<.05
Transf. Leadership --> Stress	.34	p<.05	n/A	n/A	.34	p<.05
Recovery --> Stress	-.44	p<.05	n/A	n/A	-.44	p<.05

5 Discussion

The aim of the present study was to take a closer look at the relationship between two leadership styles—health-promoting leadership and transformational leadership—and the employees' recovery–stress balance. The results indicate that both health-promoting leadership and transformational leadership have a positive effect on recovery at the workplace (H1). This is in line with the findings of Nielsen et al. (2008) and Piccolo and Colquitt (2006), where leaders are able to change work characteristics in a positive way. The second hypothesis, suggesting that both leadership styles are directly related to the employees' experience of stress, was not supported by our results. The third hypothesis, where recovery should moderate the relationship between both leadership styles and stress, could only be partially confirmed, as we did not find a moderator but a mediator instead, which is in line with the recovery–stress balance

model (Jiménez & Kallus, 2005). This indicates that both leadership styles mainly aim to enhance recovery strategies instead of reducing stress.

The second aim of the study was to compare the concepts of health-promoting leadership and transformational leadership and to identify similarities and differences. Hypothesis H4 was confirmed, as the tests of discriminant validity indicated that we are dealing with four different constructs. Looking at the underlying dimensions, correlations between both constructs are low to moderate. The lowest correlations were found between the seven health-promoting leadership dimensions and idealized attributes (MLQ). This suggests that the aim of transformational leadership, where leaders should act as a charismatic role model focusing on higher-order ideals and values do not overlap with the aim of health-promoting leadership, where reducing mismatches between the individual and the organization is a key element. Higher correlations can be found with the scale individual consideration (attending to the employees' needs by listening to their problems or helping to develop their strengths). This kind of leadership behavior can also be found in the concept of health-promoting leadership, more specifically in the dimensions control, community, and fairness.

It is the organization's responsibility to keep employees healthy and maintain them in the organization. Therefore, it is important for organizations to recognize the important role of leaders in creating a healthy workplace by giving them the possibilities to lead in a health-promoting way. Especially with the seven dimensions of health-promoting leadership, it is possible to positively change the working conditions and reduce employee stress and other negative outcomes, such as burnout.

The role of leaders in creating a healthy workplace is also very important in Slovenia. In 2011, the amendments to the Act on Occupational Safety and Health added the area of health promotion and management of psychosocial risks at the workplace. Article 32 of the Law on Safety and Health at Work (ZVZD-1, 2011) stipulated that employers have to plan and implement workplace health promotion. If leaders want to be successful in the preparation and implementation of health promotion at work, they should use health-promoting leadership. Seminars to train health-promoting leadership have already been tested in pilot applications (Jiménez, Dunkl, & Eibel, 2013). The implementation of health-promoting leadership contributes to employees' commitment to activities in work–health promotion as well as to the effectiveness of the program.

References

1. Aitken, P. (2007). 'Walking the talk': the nature and role of leadership culture within organisation culture/s. *Journal of General Management, 32(4)*, 17–37.
2. Antonovsky, A. (1997). *Salutogenese. Zur Entmystifizierung der Gesundheit*. Tübingen: dgvt-Verlag.
3. Bakker, A. B., Demerouti, E., & Euwema, M. (2005). Job resources buffer the impact of job demands on burnout. *Journal of Occupational Health Psychology*, *10(2)*, 170–180. http://dx.doi.org/10.1037/1076-8998.10.2.170
4. Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51(6)*, 1173–1182. http://dx.doi.org/10.1037/0022-3514.51.6.1173
5. Bass, B. M. (1991). From transactional to transformational leadership: Learning to share the vision. *Organizational Dynamics, 18*(3), 19–31. http://dx.doi.org/10.1016/0090-2616(90)90061-S
6. Bass, B. M., & Steidlmeier, P. (1999). Ethics, character, and authentic transformational leadership behavior. *Leadership Quarterly, 10(2)*, 181–217. http://dx.doi.org/10.1016/S1048-9843(99)00016-8
7. Brun, J., & Dugas, N. (2008). An analysis of employee recognition: Perspectives on human resources practices. *The International Journal of Human Resource Management, 19(4)*, 716–730. http://dx.doi.org/10.1080/09585190801953723
8. Cotton, P., & Hart, P. M. (2003). Occupational wellbeing and performance: A review of organisational health research. *Australian Psychologist, 38(2)*, 118–127. http://dx.doi.org/10.1080/00050060310001707117
9. Densten, I. L. (2005). The relationship between visioning behaviours of leaders and follower burnout. *British Journal of Management, 16(2),* 105–118. http://dx.doi.org/10.1111/j.1467-8551.2005.00428.x
10. Franke, F., Felfe, J., & Pundt, A. (2014). The impact of health-oriented leadership on follower health: Development and test of a new instrument measuring health-promoting leadership. *Zeitschrift für Personalforschung, 28*(1–2), 139–161.
11. Felfe, J., & Goihl, K. (2014). Deutscher Multifactor Leadership Questionnaire (MLQ). In D. Danner & A. Glöckner-Rist (Eds.), *Zusammenstellung sozialwissenschaftlicher Items und Skalen*. http://dx.doi.org/10.6102/zis22
12. Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable variables and measurement errors. *Journal of Marketing Research, 18*, 39–50. http://dx.doi.org/10.2307/3151312
13. Gill, A. S., Flaschner, A. B., & Shachar, M. (2006). Mitigating stress and burnout by implementing transformational-leadership. *International Journal of Contemporary Hospitality Management, 18*(6), 469–481. http://dx.doi.org/10.1108/09596110610681511
14. Grawitch, M. J., Gottschalk, M., & Munz, D. C. (2006). The path to a healthy workplace. A critical review linking healthy workplace practices, employee well-being, and organizational improvements. *Consulting Psychology Journal: Practice and Research, 58*(3), 129–147. http://dx.doi.org/10.1037/1065-9293.58.3.129

15. Gurt, J., Schwennen, C., & Elke, G. (2011). Health-specific leadership: Is there an association between leader consideration for the health of employees and their strain and well-being? *Work & Stress, 25*(2), 108–127. http://dx.doi.org/10.1080/02678373.2011.595947
16. Halbesleben, J. R. B. (2006). Sources of social support and burnout: A meta-analytic test of the conservation of resources model. *Journal of Applied Psychology, 91*(5), 1134–1145. http://dx.doi.org/10.1037/0021-9010.91.5.1134
17. Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling, 6*(1), 1–55. http://dx.doi.org/10.1080/10705519909540118
18. Jiménez, P., Dunkl, A., & Eibel, K. (2013). Razvoj in vrednotenje protistresnih programov za ohranjanje oz. izboljšanje dobrega počutja zaposlenih. In S. Šarotar-Žižek, S. Treven, P. Jiménez, & A. Potočnik (Eds.), *Premagovanje stresa kot sredstvo za zagotavljanje dobrega počutja* (pp. 109–116). Maribor: Univerzitetna knjižnica Maribor.
19. Jiménez, P., & Kallus, W. (2005) Stress and recovery of social care professionals: Development of a screening version of the recovery-stress-questionnaire for work. In C. Korunka & P. Hoffmann (Eds.), *Change and quality in human service work* (pp. 311–323). Munich: Hampp.
20. Jiménez, P., Winkler, B., & Dunkl, A. (2013, May). *Health relevant leadership dimensions. Development of a questionnaire to measure healthy leadership.* Poster presented at the 16th Congress of the European Association of Work and Organizational Psychology, Münster.
21. Kallus, K. W. (in press). Introduction. In K. W. Kallus & M. Kellmann (Eds.), *The recovery-stress questionnaires: User manual*. Frankfurt: Pearson Assessment.
22. Kanste, O., Kyngäs, H., & Nikkilä, J. (2007). The relationship between multidimensional leadership and burnout among nursing staff. *Journal of Nursing Management, 15*(7), 731–739. http://dx.doi.org/10.1111/j.1365-2934.2006.00741.x
23. Kelloway, K. E., & Day, A. (2005). Building healthy workplaces: Where we need to be. *Canadian Journal of Behavioural Science, 37*(4), 309–312. http://dx.doi.org/10.1037/h0087265
24. Kivimäki, M., Vahtera, J., Elovainio, M., Virtanen, M., & Siegrist, J. (2007). Effort-reward imbalance, procedural injustice and relational injustice as psychosocial predictors of health: complementary or redundant models? *Occupational and Environmental Medicine, 64*(10), 659–665. http://dx.doi.org/10.1136/oem.2006.031310
25. Langdridge, D. (2009). *Introduction to research methods and data analysis in psychology*. London: Pearson Prentice Hall.
26. Leiter, M. P., & Maslach, C. (1999). Areas of worklife: A model of the organizational context of burnout. *Journal of Health and Human Services Administration, 21*(4), 472–489.
27. Leiter, M. P., Frank, E., & Matheson, T. J. (2009). Demands, values, and burnout. Relevance for physicians. *Canadian Family Physician, 55*(12), 1224–1225.
28. Maslach, C., & Leiter, M. P. (2008), Early predictors of job burnout and engagement. *Journal of Applied Psychology, 93*(3), 498–512. http://dx.doi.org/10.1037/0021-9010.93.3.498
29. Nahrgang, J. D., Morgeson, F. P., & Hofmann, D. A. (2011). Safety at work: A meta-analytic investigation of the link between job demands, job resources, burnout, engagement, and safety outcomes. *Journal of Applied Psychology, 96*(1), 71–94. http://dx.doi.org/10.1037/a0021484
30. Nielsen, K., Randall, R., Yarker, J., & Brenner, S. (2008). The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study. *Work & Stress, 22*(1), 16–32. http://dx.doi.org/10.1080/02678370801979430
31. Piccolo, R. F., & Colquitt, J. A. (2006). Transformational leadership and job behaviors: The mediating role of core job characteristics. *The Academy of Management Journal, 49*(2), 327–340. http://dx.doi.org/10.5465/AMJ.2006.20786079
32. Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods, 40*(3), 879–891. http://dx.doi.org/10.3758/BRM.40.3.879
33. Republic of Slovenia Statistical Office. (2015). *Podatkovni portal SI-STAT, Aktivno prebivalstvo - letni podatki*. Retrieved from http://pxweb.stat.si/pxweb/Database/Dem_soc/07_trg_dela/05_akt_preb_po_regis_virih/01_07753_aktivno_preb_letno_povp/01_07753_aktivno_preb_letno_povp.asp
34. Robbins, J. M., Ford, M. T., & Tetrick, L. E. (2012). Perceived unfairness and employee health: A meta-analytic integration. *Journal of Applied Psychology, 97*(2), 235–272. http://dx.doi.org/10.1037/a0025408
35. Schermelleh-Engel, K., & Moosbrugger, H. (2003). Evaluating the fit of structural equation models: Tests of significance and descriptive goodness-of-fit measures. *Methods of Psychological Research Online, 8*(2), 23–74.
36. Schneider, B., Ehrhart, M. G., & Macey, W. H. (2013). Organizational climate and culture. *Annual Review of Psychology, 64*(1), 361–388. http://dx.doi.org/10.1146/annurev-psych-113011-143809
37. Schreurs, B., van Emmerik, H., Notelaers, G., & De Witte, H. (2010). Job insecurity and employee health: The buffering potential of job control and job self-efficacy. *Work & Stress, 24*(1), 56–72. http://dx.doi.org/10.1080/02678371003718733
38. Shain, M., & Kramer, D. M. (2004). Health promotion in the workplace: framing the concept; reviewing the evidence. *Occupational and Environmental Medicine, 61*(7), 643–648. http://dx.doi.org/10.1136/oem.2004.013193
39. Thompson, C. A., & Prottas, D. J. (2005). Relationships among organizational family support, job autonomy, perceived control, and employee well-being. *Journal of Occupational Health Psychology, 10*(4), 100–118.
40. Zakon o varnosti in zdravju pri delu/The Law on Safety and Health at Work (ZVZD-1). (2011). *Uradni list*. Retrieved from http://www.uradni-list.si/1/content?id=103969

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Podobnosti in razlike med vodenjem s poudarkom na upravljanju zdravja zaposlenih in transformacijskim vodenjem

Izvleček

Koncept vodenja s poudarkom na upravljanju zdravja se osredotoča na interakcijo med organizacijo in posameznikom ter na določanje dejavnikov, ki lahko pozitivno vplivajo na delovne pogoje zaposlenih. V študiji so bili raziskani vplivi vodenja s poudarkom na upravljanju zdravja in vplivi transformacijskega vodenja na okrevanje, stres in – ravnovesje zaposlenih. V spletni anketi je sodelovalo 212 slovenskih zaposlenih. Odgovarjali so na vprašanja o svojem zaznavanju neposredno nadrejenih, o stresu, ki je povezan z njihovim delom, in o okrevanju. Rezultati so pokazali, da imata oba stila vodenja značilen vpliv na okrevanje zaposlenih po stresu na delovnem mestu. Okrevanje na delovnem mestu je mediator pri vplivu vodstva na stres, povezan z delom.

Ključne besede: delovni pogoji, vodenje s poudarkom na upravljanju zdravja, transformacijsko vodenje, stres, okrevanje, delovno okolje